STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445314	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/18/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MORRISTOWN	501 WEST ECONOMY ROAD MORRISTOWN, TN 37814

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 1-story Type V (111), unprotected, combustible construction with a complete automatic sprinkler system, K6 PLAN APPROVAL: 1973 K7 SURVEY UNDER: 2000 EXISTING K8 SNF/NF	K029	***What corrective steps will be taken to correct this alleged deficient practice?*** The penetration through the ceiling was sealed with fire rated caulk on 5-19-2010.	6-29-10
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system protects hazardous areas in accordance with 8.4.1 and/or 19.3.5.4 . When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure hazardous area ' s one (1) hour fire rated construction is maintained. This deficient practice affected one of six smoke compartments. The findings include: Observation and interview with the Maintenance Director, on May 18, 2010 at 11:20 a.m. confirmed the 100 hall hot water heater vent penetration through the ceiling was not sealed and had a one-inch gap around the vent pipe exposing wood frame construction to the attic.		***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?*** No residents affected this is not a resident care area. A house wide assessment by Maintenance Associates of areas where wall penetration has occurred will be conducted to assess for unsealed area(s). ***What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?*** Quarterly assessment by Maintenance Associates of the physical plant for areas of potential issue that seal is worn or nonexistent and follow-up behind any contractor or vendor who has performed work for facility will be conducted to assure no unsealed areas at wall penetration. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?***	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Hollie Coates Hensley — TITLE: ED — (X6) DATE: 06/04/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

7-1-10 Rec'd Extension Request

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS 42 CFR 483.70(a) K3 BUILDING: 1-story Type V (111), unprotected, combustible construction with a complete automatic sprinkler system. K6 PLAN APPROVAL: 1973 K7 SURVEY UNDER: 2000 EXISTING K8 SNF/NF		A Performance Improvement Plan will developed and be presented at the June 2010 PI meeting. PI members: Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, RN/LPN Unit Managers, Pharmacy Consultant, Registered Dietitian, Certified Dietary Manager, Rehab Services Manager, Business Office Manager, Medical Records, Admissions Coordinator and Activities Director.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with 3/4 hour fire-rated doors) or an approved automatic fire extinguishing system protects hazardous areas in accordance with 8.4.1 and/or 19.3.5.4 . When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure hazardous area ' s one (1) hour fire rated construction is maintained. This deficient practice affected one of six smoke compartments. The findings include: Observation and interview with the Maintenance Director, on May 18, 2010 at 11:20 a.m. confirmed the 100 hall hot water heater vent penetration through the ceiling was not sealed and had a one-inch gap around the vent pipe exposing wood frame construction to the attic.		**K038** ***What corrective steps will be taken to correct this alleged deficient practice?*** Exit doors exiting from dining room and door exiting from Secured Unit will addressed with signage that reflects "push until alarm sounds—door can be opened in 15 seconds". Completion by 6-15-2010. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?*** All residents have potential to be affected by this practice. Maintenance Associates will affix the signage to these exits to denote ability of doors to open when pushed, alarm sounds and 15 seconds pass.	6-29-10
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 038	Continued From page 1 Exit access is arranged so that exits are readily accessible at all times in accordance with 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide instructional signage for operation of three (3) of nine (9) observed exit doors with delayed-egress magnetic locks. This deficient practice affected two of six smoke compartments. Findings include: Observation and interview with the Maintenance Director, on May 18, 2010 at 1:20 p.m. confirmed two exits exiting the dining room and one door exiting the Secured Unit had delayed-egress magnetic locking hardware and was not provided with a sign reading, " PUSH UNTIL ALARM SOUNDS - DOOR CAN BE OPENED IN 15 SECONDS " .(NFPA 101, Sec. 7.2.1.6.1)		***What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?*** All exit doors will be assessed by Maintenance Associates for appropriate signage quarterly to make sure it is intact, in good repair and visible. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** A Performance Improvement Plan will be initiated immediately and will be reviewed in June 2010 PI Committee Meeting. Members include: Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, RN/LPN Unit Managers, Pharmacy Consultant, Registered Dietitian, Certified Dietary Manager, Rehab Services Manager, Business Office Manager, Medical Records, Admissions Coordinator and Activities Director	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure outside exits were lighted. The findings include: Observation with the Maintenance Director, on May 18, 2010 at 2:30 p.m. confirmed the outside lights at the exits from the 200 long hall, 300 long	K045	***What corrective steps will be taken to correct this alleged deficient practice?*** All outside exits were assessed by Maintenance Associates for appropriate lighting, bulbs changed that were inoperable. Completed 5-20-2010	6-29-10

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K 038	Continued From page 1 Exit access is arranged so that exits are readily accessible at all times in accordance with 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide instructional signage for operation of three (3) of nine (9) observed exit doors with delayed-egress magnetic locks. This deficient practice affected two of six smoke compartments. Findings include: Observation and Interview with the Maintenance Director, on May 18, 2010 at 1:20 p.m. confirmed two exits exiting the dining room and one door exiting the Secured Unit had delayed-egress magnetic locking hardware and was not provided with a sign reading, " PUSH UNTIL ALARM SOUNDS - DOOR CAN BE OPENED IN 15 SECONDS " .(NFPA 101, Sec. 7.2.1.6.1)		***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?*** In the event of an emergency all residents could be affected. All light bulbs were assessed by Maintenance Associates for operation and were replaced if needed. ***What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?*** Light bulbs to outside lights will be assessed by Maintenance Associates for operation and effectiveness on a weekly round and as needed. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** A Performance Improvement Plan will be developed to address exit lightings and future monitoring of operation of these lights and presented at June 2010 PI Committee Meeting. Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, RN/LPN Unit Managers, Pharmacy Consultant, Registered Dietitian, Certified Dietary Manager, Rehab Services Manager, Business Office Manager, Medical Records, Admissions Coordinator and Activities Director	
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure outside exits were lighted. The findings include: Observation with the Maintenance Director, on May 18, 2010 at 2:30 p.m. confirmed the outside lights at the exits from the 200 long hall, 300 long			

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K 045	Continued From page 2 hall, and 300 short hall were not provided with exit lighting outside the exit discharge door. Interview with the Maintenance Director revealed the lights had been removed when the soffits were replaced. K 062 NFPA 101 LIFE SAFETY CODE STANDARD SS=D Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure sprinkler heads were free of corrosion. The findings include: Observation and interview with the Maintenance Director, on May 18, 2010 at 2:40 p.m. confirmed the sprinkler head outside the 300 short hall exit door was corroded. K 070 NFPA 101 LIFE SAFETY CODE STANDARD SS=D Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure extension cords and multiple outlet adapters were not used (NFPA 99, 3-3.2.1.2 (d) (2) states: There shall be sufficient receptacles located so as to avoid the need for	K062	***What corrective steps will be taken to correct this alleged deficient practice?*** An outside vendor called to facility to assess sprinkler heads on 6-1-2010 and assessed all sprinkler heads of facility. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?*** All residents have potential to be affected by sprinkler head corrosion. A house wide assessment by Maintenance Associates and Outside Sprinkler Vendor of all sprinkler heads was conducted and replacement to those affected will take place by 6-15-2010. ***What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?*** A monthly audit by Maintenance Associates of sprinkler heads will be conducted during the cleaning of these heads. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** A Performance Improvement Plan will be established to address sprinkler head issues and audits of condition of	6-29-10

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K 045	Continued From page 2 hall, and 300 short hall were not provided with exit lighting outside the exit discharge door. Interview with the Maintenance Director revealed the lights had been removed when the soffits were replaced.		sprinkler heads will be presented at the June 2010 PI Committee Meeting. Members include: Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, RN/LPN Unit Managers, Pharmacy Consultant, Registered Dietitian, Certified Dietary Manager, Rehab Services Manager, Business Office Manager, Medical Records, Admissions Coordinator and Activities Director	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure sprinkler heads were free of corrosion. The findings include: Observation and interview with the Maintenance Director, on May 18, 2010 at 2:40 p.m. confirmed the sprinkler head outside the 300 short hall exit door was corroded.	K070	***What corrective steps will be taken to correct this alleged deficient practice?*** Immediately upon discovery of equipment plugged into power strips the Maintenance Department surveyed each resident room to assure no other extension or surge device was in use for medical devices by 5-20-2010. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?*** All resident rooms will be inspected for power cord usage for medical devices by 5-20-2010.	6-29-10
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure extension cords and multiple outlet adapters were not used (NFPA 99, 3-3.2.1.2 (d) (2) states: There shall be sufficient receptacles located so as to avoid the need for			

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K 045	Continued From page 2 hall, and 300 short hall were not provided with exit lighting outside the exit discharge door. Interview with the Maintenance Director revealed the lights had been removed when the soffits were replaced.		***What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?*** Divisional Director of Maintenance and renovation has been contacted to quickly evaluate with Licensed electrician the availability of sufficient electrical outlets with recommendations for improvement to assure ample outlets for resident medical equipment use. Nursing Associates will be inserviced by Maintenance Director on proper outlet usage annually. Maintenance Staff to do monthly room inspections for power outlets in use to service medical devices. These findings will be documented in the Facility Preventive Maintenance Logs.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure sprinkler heads were free of corrosion. The findings include: Observation and interview with the Maintenance Director, on May 18, 2010 at 2:40 p.m. confirmed the sprinkler head outside the 300 short hall exit door was corroded.		***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** A Performance Improvement Plan will be presented at the June 2010 PI meeting. Recommendations from Master Electrician will be gathered and	
K 070 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices are prohibited in all health care occupancies, except in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 19.7.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to assure extension cords and multiple outlet adapters were not used (NFPA 99, 3-3.2.1.2 (d) (2) states: There shall be sufficient receptacles located so as to avoid the need for			

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K 070	Continued From page 3 extension cords or multiple outlet adapters.) This has the potential to affect one (1) of six (6) smoke compartments. The findings include: Observation and interview with the Maintenance Director on May 18, 2010 at 1:15 p.m. confirmed power strips were used for medical devices in resident rooms 102 (feeding pump) and 118 (Oxygen concentrator).		presented—monitoring of this issue x 3months or till rectified. Members include: Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, RN/LPN Unit Managers, Pharmacy Consultant, Registered Dietitian, Certified Dietary Manager, Rehab Services Manager, Business Office Manager, Medical Records, Admissions Coordinator and Activities Director	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1, NFPA 110. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide the emergency generator with a remote annunciator in a continuously monitored location. (NFPA 99, 3-4.1.1.15 and NFPA 70, Section 700-12) The findings include: Observation and interview with the Maintenance Director, on May 18, 2010 at 4:20 p.m. confirmed the facility was not provided with a remote annunciator for the emergency generator.		K144 ***What corrective steps will be taken to correct this alleged deficient practice?*** It is the practice of this facility to assure that the generator system is maintained to be in compliance at all times with Life Safety Code NFPA 110, NFPA 99 and NFPA 101 to include: Evaluation of generator potential for an annunciator to be installed in a location that can be monitored 24 hours a day. ***How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?*** Facility generator is operable and in good repair and function. Division Director of Maintenance and Renovation has been contacted to quickly evaluate with Licensed Electrician the ability to connect an enunciator to existing previously approved and currently maintained generator installation.	6-29-2010

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K 070	Continued From page 3 extension cords or multiple outlet adapters.) This has the potential to affect one (1) of six (6) smoke compartments. The findings include: Observation and interview with the Maintenance Director on May 18, 2010 at 1:15 p.m. confirmed power strips were used for medical devices in resident rooms 102 (feeding pump) and 118 (Oxygen concentrator).			
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1, NFPA 110. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide the emergency generator with a remote annunciator in a continuously monitored location. (NFPA 99, 3-4.1.1.15 and NFPA 70, Section 700-12) The findings include: Observation and interview with the Maintenance Director, on May 18, 2010 at 4:20 p.m. confirmed the facility was not provided with a remote annunciator for the emergency generator.		***What measures will be put into place or what systematic changes you will make to ensure that the deficient practice does not recur?*** In the event an enunciator can be installed, the enunciator will be installed by 8-20-2010. If it is found that an enunciator panel can be retrofitted with the previously approved and currently maintained generator, the facility will be will be assessed and quoted for a new generator installation with enunciator by 8-20-2010. ***How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?*** Maintenance Director will monitor ennunciator operation during monthly generator load test and document in the Preventive Maintenance Generator Logs. These findings along with a Performance Improvement Plan will be present in PI monthly times 3 months. Attendees to PIT meeting include: Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services, RN/LPN Unit Managers, Pharmacy Consultant, Registered Dietitian, Certified Dietary Manager, Rehab Services Manager, Business Office Manager, Medical Records, Admissions Coordinator and Activities Director	